Description of Service Limitations

9. **CLINIC SERVICES:** "Clinic Services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520-47.30.620, state operated community mental health clinics, and mental health physician clinics. Ambulatory surgical clinic services and renal disease physician clinics are provided as separate services.

10. **DENTAL SERVICES:** See Attached Sheet to Attachment 3.1A, Page 3a.

11.a-c. **PHYSICAL THERAPY AND RELATED SERVICES:** See Attachment 3.1A, Page 24a-d.

12.a. **PRESCRIBED DRUGS**

(1) The following prescribed drugs are included:

(a) drugs, which require a prescription, except for those drugs specifically excluded;

(b) a compounded prescription, if at least one ingredient requires a prescription for dispensing and the recipient's drug therapy needs cannot be met by commercially available dosage strengths or forms
of the therapy;

Claims for compound drugs are submitted using the national drug code (NDC) number and quantity for each compensable ingredient in the compound;

No more than 25 ingredients are reimbursed in any compound; and

Reimbursement for each drug component is determined in drug the Department reimbursement methodology.

(c) an outpatient drug for which payment under CMS' drug rebate program is is not covered, except that the department will pay for

(A) active pharmaceutical ingredients for which a drug rebate is unavailable, if the ingredient is used in a compounded prescription in accordance with (1)(b)of this section; and

(B) laxatives and bismuth preparations in accordance of (1)(f) of this section.

(2) Drugs not otherwise specifically excluded from payment may be covered only after prior authorization has been obtained by the Division. These drugs may be further limited on the minimum and maximum quantities per prescription or on the number of refills to discourage waste and address instances of fraud or abuse by individuals. The Division will ensure a response to each prior authorization request is provided within 24 hours. In emergency situations, at least a 72-hour supply of the covered outpatient prescription may be dispensed.

(3) A pharmacy shall maintain documentation of receipt of prescribed drugs by recipients. The documentation may be kept as a signature log showing which prescription numbers are received or as mailing labels if prescribed drugs are mailed to the recipient.

(4) A provider that dispenses drugs in unit doses to a recipient in a nursing home or other long term care facility shall return unused medications to the pharmacy and the claim shall be adjusted.

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s)		Provision(s)
1927 42 CFR 447.201 42 CFR 440	X	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific categories below)
	X	(h) barbiturates
	X	(i) benzodiazepines
	X	(j) smoking cessation (except for dual-eligibles beginning January 1, 2006.)

(The Medicaid agency lists specific category of drugs below)

X	(k) Drugs for weight gain (Anabolic Steroids); Megace Oral Suspension
X	(l) All cosmetic drugs are covered except hair growth drugs, which are not covered
X	(m) Prescription vitamins: oral vitamins, folic acid, Vitamin A, Vitamin K, Vitamin D, and analogs, Vitamin B Complex when medically necessary.
X	(n) Non-prescription drugs: laxatives and bismuth preparations, vaginal antifungal creams and suppositories, Nonoxyl 9 contraceptives, Bacitracin Topical Ointment, Tobacco cessation drugs, loratadine, omeprozole.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Advanced Nurse Practitioners

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 02/09/12, to be effective for services on or after 12/01/11.

Ambulatory Surgical Clinic Services

Payment is made to ambulatory (outpatient) surgical clinics on a prospectively determined rate. Payment covers all operative functions attendant to medically necessary surgery performed at the clinic by a private physician or dentist, including admitting and laboratory tests, patient history and examination, operating room staffing and attendants, recovery room care, and discharge. It includes all supplies related to the surgical care of the beneficiary while in the clinic. The payment excludes the physician, radiologist, and anesthesiologist fee. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 03/02/10, to be effective for services on or after 01/01/10.

Behavior Rehabilitation Services

Payment for Behavior Rehabilitation Services is a fee-for-service basis, with one day being the unit of service. Rates are based upon a periodic rate study using a prospective staffing based rate model that uses data gathered by the State Department of Labor reporting the prevailing wages in the State of Alaska. Specific position classifications were selected to reflect the comparable staffing requirements needed to provide quality rehabilitation services to the identified population. A factor is used to compensate for employee benefits and facility operating costs and supplies. Board and room are not included in the Behavior Rehabilitation Services rate paid to the provider. These rates are periodically adjusted based on appropriate cost-of-living adjustments and other market indicators and program standards. Rates and rate methodology are found in the Office of Children's Services Residential Behavioral Health Services Handbook 2010 at: http://www.hss.state.ak.us/ocs/ResidentialCare/docs/2009_BRS_Handbook.pdf

Chiropractic Services

Payment for manual manipulation to correct subluxation of the spine and x-rays is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 02/17/12, to be effective for services on or after 12/01/11.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Dental Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 08/10/11, to be effective for services on or after 07/01/11.

Direct Entry Midwife Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 02/10/12, to be effective for services on or after 12/01/11.

EPSDT Screening Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale Methodology for physicians, or the provider's lowest charge. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 03/02/12, to be effective for services on or after 12/01/11.

Midwife Birthing Center Services

Rates for midwife services provided in a birthing center are based on the lesser of billed charges, 85% of the Medicare Resource Based Relative Value Scale Methodology used for physicians in the current year, or the provider's lowest charge, plus an amount equal to 50% of the statewide average rate for a normal vaginal hospital birth for the previous state fiscal year. See fee schedule rates for Advanced Nurse Practitioners (p.1 of this attachment) and Direct Entry Midwives (page 1.1 of this attachment) for fee schedule rates.

Methods and Standards for Establishing Payment Rates: Other Types of Care

Physician Services

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale (RBRVS) methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established Relative Value Unit (RVU). The Resource Based Relative Value Scale methodology is that described in 42 CFR 414 except that increases and reductions to the average payment made for an individual procedure code billed at least ten times during the previous fiscal year will be phased in until the year 2000. The relative value units used are the most current version published in the Federal Register. Non-routine office supplies are reimbursed at the lesser of billed charges or the state maximum allowable.

Payment for the services of a physician collaborator is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Physician collaborators are a physician assistant, advanced nurse practitioner, physical therapist, occupational therapist, audiologist, speech language pathologist, certified registered nurse anesthetist, or a community health aide III or IV or a community health practitioner certified by the state.

Surgical reimbursement is in accordance with the Resource Based Relative Value Scale methodology except that multiple surgeries performed on the same day are reimbursed at 100 percent of the RBRVS rate for the highest procedure and 50 percent of the RBRVS rate for each additional surgery; bilateral surgeries are reimbursed at 150 percent of the RBRVS rate; co-surgeons are reimbursed by increasing the RBRVS rate by 25 percent and splitting payment between the surgeons; and supplies associated with surgical procedures performed in a physician's office are reimbursed at the lesser of billed charges or the state maximum allowable. Payment is made to surgical assistants at the lesser of billed charges or 25 percent of the Resource Based Relative Value Scale methodology.

Laboratory services are reimbursed at the lesser of the amount billed the general public or the Medicare fee schedule.

Payment is made to independently enrolled hospital-based physician for certain services at the lessor of the amount billed the general public or 100 percent of the Resource Based Relative Value Scale methodology.

Anesthesia services are reimbursed using base units and time units and a state determined conversion factor.

State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 02/02/12, to be effective for services on or after 12/01/11

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Podiatry Services

Payment is at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/FeeSchedule.asp. The fee schedule was last updated on 03/02/10, to be effective for services on or after 01/01/10.

Prescribed Drugs

(a) Reimbursement will be made to the provider for reasonable and necessary postage or freight costs incurred in the delivery of the prescription from the dispensing pharmacy to a recipient in a rural area. Cross-town postage or delivery charges are not covered. Handling charges are included in the dispensing fee (below) and not directly reimbursed.

(b) The payment for multiple source drugs for which the Centers for Medicare and Medicaid has established a specific upper limit amount will be the lowest of the amount billed, estimated acquisition cost, state maximum allowable cost or the federal upper limit plus the dispensing fee.

(c) The payment for drugs other than those of (b) above, and for brand names of multiple source drugs specified by the prescriber in accordance with 42 C.F.R. 447.331 will be the dispensing fee plus the in state estimated acquisition cost of that drug, which is the wholesale acquisition cost published by First Data Bank as updated weekly plus 8 percent of that amount, the payment will not exceed the lower of the estimated acquisition cost plus the dispensing fee or the provider's lowest charge. Physician and advance nurse practitioner administered drugs are reimbursed at the lower of the billed amount or Wholesale Acquisition Cost plus 8 percent.

(d) For out-of-state providers the estimated acquisition cost is the wholesale acquisition cost plus 1 percent.

(e) The payment for compounding prescriptions will be the sum of the costs of each of the ingredients as established under (b) or (c) (above), plus the compounding dispensing fee to reimburse no more than the provider's lowest charge.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

(f) The department establishes a state maximum allowable cost for a drug if two or more therapeutically equivalent, multisource, non-innovator drugs exist for the given drug; and by reviewing the pricing sources, wholesale acquisition cost and direct price for the drug as identified in the First Data Bank file.

(g) Reconsideration of a state maximum allowable cost price for a drug is subject to the following procedures:
(1) the provider must submit, by electronic mail or facsimile transmission, a completed *Alaska Medicaid MAC Price Research Request Form*, ; the provider must include with the form a copy of the invoice listing the current acquisition cost;
(2) the provider must contact the department in writing and must include all information supporting the request for reconsideration, including the national drug code (NDC) for the drug in question;
(3) a request for reconsideration of a state maximum allowable cost price for a drug will be investigated and resolved no more than three days after the department receives the written contact described in (2) of this subsection;
(4) the provider will be supplied with the names, if available, of one or more manufacturers that have a price comparable to the state maximum allowable cost price;
(5) the state maximum allowable cost price and effective date of that price will be adjusted accordingly, retroactive to the date of service for the state maximum allowable cost price prescription in question, if
i. the department determines that all manufacturers' costs exceed the state maximum allowable cost; or
ii. the provider is able to document that despite reasonable efforts to obtain access, the provider does not have access to the one or more manufacturers whose names the department supplied to the provider;
(6) when the change in state maximum allowable cost price for a price that is adjusted becomes effective, the provider will be informed that the claim may be resubmitted for the price adjustment.

(h) Wholesale acquisition cost with respect to a drug or biological, means the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

(i) The dispensing fee is based on the results of surveys of in-state pharmacies' cost of dispensing prescriptions. For each pharmacy, the dispensing fee will be determined using the following schedule:
  (1) for a low-volume pharmacy, the dispensing fee is $26.74, to be paid no more than once every 28 days per individual medication strength;
  (2) for a medium-volume pharmacy, the dispensing fee is $16.98, to be paid no more than once every 28 days per individual medication strength; and
  (3) for a high-volume pharmacy, the dispensing fee is $12.12, to be paid no more than once every 28 days per individual medication strength.
  (4) The dispensing fee for an out-of-state pharmacy is $3.50, to be paid no more than once every 28 days per individual medication strength.
  (5) A dispensing provider located over 45 miles from a retail pharmacy that is not a covered entity under 42 USC 256b will receive a dispensing fee of $5.73.
  (6) In addition to a dispensing fee, a mediset fee of $5.00 per claim to be billed no more than once every seven days will be paid to a mediset pharmacy for recipients in congregate living homes, recipients on a home and community based waiver, and children eligible for Medicaid services under the Tax Equity and Fiscal Responsibility Act of 1982.
  (7) In this section,
    i. "high-volume pharmacy" means a pharmacy filling more than 85,000 prescriptions a year;
    ii. "low-volume pharmacy" means a pharmacy filling fewer than 29,500 prescriptions a year;
    iii. "medium-volume pharmacy" means a pharmacy filling at least 29,500 and no more than 85,000 prescriptions a year.

(j) A pharmacy may not refuse to fill an interim prescription occurring before the end of 28 days as the monthly dispensing fee covers the monthly period.

(k) Payment is restricted to drugs supplied by manufacturers who have a signed national agreement or an approved existing agreement under the Medicaid Drug Rebate program of Sec 1902(a)(54) and Sec. 1927 of the Act, and the only drugs supplied by such manufacturers that are not reimbursed are those excluded under Attached Sheet to Attachment 3.1A.

(l) The department will pay, the lesser of the pharmacy's assigned dispensing fee, as specified in section (i) or the submitted dispensing fee. A newly established in-state pharmacy that does not have the information available to establish a fee will be assigned the lowest dispensing fee of $12.12 until that pharmacy can provide 12

Methods and Standards for
Establishing Payment Rates: Other Types of Care

months of prescription data to the department, after which the new dispensing fee will be applied to pharmacy payments within two weeks for future prescription claims.

(m) The compound dispensing fee for an in-state pharmacy is the lowest of the submitted compound dispensing fee; or two times the assigned dispensing fee in (i) of this section.

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Clozapine Medication Therapy Management

Pharmacies providing prescribed clozapine medication therapy through a qualified pharmacist to a recipient with a prescription will be paid the lesser of billed charges or $15 for clozapine medication therapy management fee no more than once every 30 days.

Tobacco Cessation

Phamacies providing prescribed tobacco cessation medication therapy management through a qualified pharmacist to a recipient with a prescription will be paid the lesser of billed charges or the rate paid to an advanced nurse practitioner for services assigned code 99406 in the Current Procedural Terminology, Professional Edition, adopted by reference in 7 AAC 160.900.

State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/Billing1.shtml. The fee schedule was last updated on 02/08/12, to be effective for services on or after 12/01/11.

Vaccine Reimbursement

For Medicaid eligible individuals through 18 years of age –

1) Administration of Preventive Vaccines is only reimbursed via an Administration fee to participating/enrolled Alaska VFC providers under the Vaccines for Children (VFC) program. Information regarding the VFC program is found on page 66(b) of Alaska's Medicaid State plan.

For Medicaid eligible individuals aged 19 and over –

1) Qualified, enrolled, licensed, Medicaid providers in Alaska practicing within their scope of practice will be reimbursed an administration fee as follows:
   a) Physicians will be reimbursed the lesser of billed charges or 100% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.

   b) Nurse practitioners and physicians assistants will be reimbursed the lesser of billed charges or 85% of the applicable physician CPT code and/or the applicable vaccine CPT code as of the effective date of October 1, 2009, and subsequently modified by any annual/periodic adjustments to the fee schedule.

   c) Pharmacists will be reimbursed the lesser of the estimated acquisition cost or billed charges plus an administration fee of $17.46. Qualified pharmacists as authorized under "Other Licensed Practitioners" at 42 CFR 440.60 are not eligible to receive a dispensing fee for vaccines when an administration fee is paid.

   State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule and its effective dates are published at http://www.medicaidalaska.com/providers/Billing.shtml. The fee schedule was last updated on 02/02/12, to be effective for services on or after 12/01/11.